Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

Inefficacy of cimetidine in condylomata acuminata

Sir,

Condylomata acuminata form one of the most frustrating ailments to manage. Clinical and in-vitro observations suggest that a refractory course of condylomata may be a reflection of an underlying state of cellular immunosuppression.[1] Recently, cimetidine has been shown to possess immunomodulatory properties; its mode of action is probably related to the inactivation of suppressor cells.[2] In two experimental models[3,4] cimetidine has been highly effective in reducing the number of metastatic deposits and in increasing the life-span of tumour-bearing animals. Since cimetidine was not directly cytotoxic to tumour cells in vitro, its activity could be ascribed to the augmentative effect on the immune response.[4] On the basis of these data we studied the efficacy of cimetidine as an adjuvant in treating chronic condylomata acuminata.

Twelve healthy patients aged 19-39 years (11 men and one woman) entered the study. All had multiple venereal warts of 4-60 months' duration, and all had been unsuccessfully treated before. Local treatment consisted of podophyllin 10-20% in collodion once weekly until all lesions had resolved. Cimetidine 400 mg was given four times daily for eight weeks. Two patients refused further treatment after four weeks because of exacerbation during treatment. Ten patients completed their treatment course, of whom eight had persistent condylomata at the end of the trial period and after 1-3 months' follow up. One patient defaulted, but inquiry by telephone indicated that all the lesions had completely resolved. In only one case could a complete cure be claimed. This patient had frenal lesions only. Side effects were not found. Interestingly, three patients had concomitant common warts on the hands or feet, none of which showed any improvement during treatment with cimetidine.

These findings show that cimetidine has a negligible effect on venereal warts. Thus, a randomised prospective study in this field seems unwarranted.

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TO THE EDITOR, *British Journal of Venereal Diseases*

Post-gonococcal cervicitis and post-gonococcal urethritis

Sir,

We were interested to read of the high incidence of post-gonococcal urethritis and cervicitis in a recent article.[1] We rarely see such conditions in this clinic nowadays.

Because of the reported high rate of coincidental infection with chlamydia, we give all patients with gonorrhoea (male and female) a 10-day course of oxytetracycline (500 mg twice daily). This course is the same as we use for non-specific urethritis (NSU) and contacts of non-specific urethritis, and is given after ampicillin 2 g and probenecid 1 g in one immediate oral dose. We have never regretted giving oxytetracycline in these cases. Such a regimen is associated with a low incidence of post-gonococcal syndromes (3%), low treatment failure rates for gonorrhoea (<1%), and therefore less necessity for long-term follow up. One disadvantage may be that an increased number of women develop candidosis but this is usually diagnosed and treated before the final follow-up visit.

This management may not meet strictly academic ideas of "diagnosis before treatment," but in the absence of chlamydial cultures there seems no practical acceptable alternative (compare NSU and NSU contacts). Even if only a small percentage of men and women treated for gonorrhoea avoid chlamydial epididymitis or salpingitis by this means, it is surely worthwhile. In addition, it decreases the likelihood of partners reinfecting each other with chlamydia.

Yours faithfully,

Michael J Balsdon
S R S Laing
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Department of Genitourinary Medicine,
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Portsmouth,
Hants

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TO THE EDITOR, *British Journal of Venereal Diseases*

Aetiology and management of non-specific vaginitis

Sir,

Dr Dattani and his colleagues[1] are to be congratulated in attempting to tackle the complex clinical and microbiological features of the ubiquitous and distressing non-specific vaginitis. They do, however, seem to be basing their assumption, that most cases of *Gardnerella vaginalis* vaginitis are cured spontaneously, on the 10 cases in their treatment control group who regressed without treatment. I would suggest that this is a little premature. Our experience of *G vaginalis* vaginitis in Sheffield over five years (and 5000 patients) suggests that certainly some cases cured themselves, but this is by no means the rule.

Yours faithfully,

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Reference

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TO THE EDITOR, *British Journal of Venereal Diseases*

False-negative reagin test results to non-agglutinating (incomplete) antibodies

Sir,

We wish to report two cases of clinically active syphilis in which the results of the rapid plasma reagin (RPR) test for measuring antibodies to cardiolipin were negative and the *Treponema pallidum* indirect haemagglutination assay (TPHA) and fluorescent treponemal antibody (FTA) tests were positive. The FTA test result was

positive for both IgG and IgM antibodies. In view of the fact that the IgG antibodies were strongly positive we considered it unlikely that these were cases of early syphilis with low RPR values due to early stage disease.[1] We suspected that these individuals may have produced antibodies of the non-agglutinating or incomplete type and therefore performed a Kolmer complement-fixation test (CFT) using Difco cardiolipin-lecithin antigen (Detroit, Michigan, USA) as well as a Coombs antiglobulin test on both specimens.

The Coombs antiglobulin test was performed using equal volumes of undiluted patients' sera and charcoal particles on to which cardiolipin was adsorbed (VDRL carbon antigen, Wellcome Research Laboratories, Beckenham, Kent). Normal control sera as well as phosphate-buffered saline (PBS 0·15 mol/l) were used as negative controls. The mixtures were rotated for 10 minutes followed by three washing steps in PBS to remove unbound serum components. After the final wash 0·2 ml Coombs reagent (goat anti-human globulin, Institute Pasteur, Paris) was added to the charcoal particles, incubated overnight at 37°C, and assessed the following day for agglutination. The serological results are shown in the table.

The positive results for IgM show that in case 1 the patient had active syphilis. Although the RPR test result was negative the Kolmer CFT and Coombs test, which measured non-specific antibodies to cardiolipin, gave positive results showing the presence of incomplete antibodies to cardiolipin. The results obtained on the second patient (case 2) were similar except that the Kolmer CFT result was negative. This may have been due to the presence of an incomplete antibody with poor complement-binding activity. Darkfield examination for detection of *Treponema pallidum* was not performed.

Clinical diagnoses of active syphilis had been made for both patients, but it was possible only to obtain a case history as well as follow-up sera from the first patient. This 46-year-old man attended the clinic for sexually transmitted diseases on 12 November 1981 complaining of a penile ulcer, which had been present for two weeks. He later also admitted having a urethral discharge for three weeks and denied extramarital sexual contact. On examination the right inguinal lymph glands were greatly enlarged, he had a profuse, thick, grey urethral discharge, and there was a large ulcer at the corona (about 15 mm in diameter). Clinically the ulcer looked like a chancre, but the inguinal lymphadenitis made the diagnosis of chancroid more probable. Smears of the urethral discharge gave negative results for *Neisseria gonorrhoeae* (no culture was performed).

Treatment consisted of a single intramuscular injection of benzylpenicillin (5 million units); weekly injections of benzathine penicillin (2·4 million units for two weeks; and long-acting sulphonamides (one tablet daily for two weeks). On 4 December all that remained was a small scab at the site of the penile ulcer; the results of serological investigations are shown in the table. The patient's wife also had clinically active syphilis (table).

These results indicate that incomplete antibodies to cardiolipin may occasionally complicate the serodiagnosis of syphilis. The incidence of such antibodies is not yet known but is probably low. The importance of using the TPHA as a screening test with subsequent investigation of positive specimens for IgM antibodies by the FTA-ABS test is emphasised.

TABLE *Serological test results of two patients with clinically active syphilis*

	Results of serological tests					
	RPR	*TPHA*	*FTA-ABS*			
Patients			*IgG*	*IgM*	*Kolmer CFT*	*Coombs test*
Case 1						
Initial results	–	+	3+	1+	1/64	+
On 4.12.81	–	+	1+	–	–	–
Case 2						
Initial results	–	+	3+	1+	–	+
Wife*	1/16	+	4+	–		

+ Positive; – negative
*Of the patient in case 1
RPR = rapid plasma reagin (test); TPHA = *Treponema pallidum* haemagglutination assay; FTA-ABS = fluorescent treponemal antibody-absorption (test); CFT = complement-fixation test

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1. O'Neill P. A new look at the serology of treponemal diseases. *Br J Vener Dis* 1976; **52**;296.

Notices

Medical mycology

A postgraduate course in medical mycology (dermatomycology) is to be held from 16-18 September 1982 at the University of California, San Francisco, USA. For further information please write to: Extended Programs in Medical Education, Room 569-U, School of Medicine, University of California, San Francisco, California 94143, USA (telephone No: 666-4251).

Retirement symposium

A one-day symposium on sexually transmitted diseases is being held in honour of Dr C S Ratnatunga, FRCP(Ed), on Friday 24 September 1982 at the Royal Free Hospital, Pond Street, London NW3. You are invited to contact the Marlborough Department of Venereology at this address for details.